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The continuity of hospital nursing care for Primary Health Care in Spain*

A continuidade do cuidado de enfermagem hospitalar para a Atenção Primaria à Saúde na Espanha

La continuidad del cuidado de enfermería hospitalaria para la Atención Primaria de Salud en España

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ABSTRACT

Objective: To learn the profile and activities carried out by the Hospital Nurse Liaison for the continuity of care in Primary Health Care in Spain. **Method:** An exploratory study with a qualitative approach developed in five University Hospitals in Madrid and three in Barcelona, with Hospital Nurse Liaisons who work in Hospitals in Madrid (8) and Barcelona (11). An online questionnaire was applied with open and closed questions for data collection. The data were analyzed by the content analysis technique in the thematic modality. **Results:** Nineteen (19) Hospital Nurse Liaisons participated in the study. The liaisons' ages ranged from 26 to 64 years old, the majority were women (94.73%) with experience between 21 and 30 years (52.63%), and had worked in this job between 6 months and 26 years. The Nurse Liasion is required to perform a clinical assessment of the patient prior to discharge and to contact the Nurse in the patient's area of origin by telephone or e-mail. It is necessary to have experience as an educator, to work in a team and have motivation. **Conclusion:** Nurses in Spain perform care continuity for Primary Health Care, in which their activities encompass the availability of resources and experience in managing the care of complex patients and their families.

DESCRIPTORS

Transitional Care; Patient Discharge; Continuity of Patient Care; Community Health Nursing; Home Health Nursing; Integrality in Health.

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INTRODUCTION

Comprehensiveness is a principle of the health sector and refers to an articulated and continuous set of preventive and curative, individual and collective actions and services which are required for each case and at all complexity levels of the health system[1].

The absence of this principle is one of the criticisms of the clinical care model, which has a biological focus and values specialist knowledge, thus fragmenting care. There is an undervaluation of the general education of health professionals in this model, since it privileges incorporating high technological density which entails high costs for health production, in addition to articulating itself to the functionalist way of organizing the work centered on tasks, and is still existing in nursing work in hospital units in Spain and around the world[2].

However, with the global changes in health sector policies and structures, care practices have been incorporated in a broader, more integrated and articulated clinical perspective. In Brazil, such practices and principles, as well as the current Health Care Networks (*RAS – Redes de Atenção à Saúde*) policy, are more in line with the public health system; a fact that impacts planning and execution of healthcare issues in order to organize the care work process in healthcare services[3].

Care continuity after the patient discharge in an RAS type model is ensured through an adequate transition process. Transition is defined as a set of actions aimed at coordination and care continuity, such as the transfer between different places or between different care levels[4].

The transition involves the patient, family members, caregivers and the professionals who perform the care, thereby aiming at care continuity. Therefore, it is a complex process that requires proper professional communication, knowledge, experience, competence and skills. Adequate transition results in quality patient care and in the lives of patients, helps to prevent further hospitalizations and reduces hospital costs. Nurses should ensure patients return home with the support they need and mediate the resources with Primary Care professionals to accomplish a successful transition process[4].

Coordinated care between the hospital and the home can be hindered by work overload, limitations in the involvement of a multidisciplinary team of professionals, and lack of a systematic strategy for the education and ongoing guidance of patients, caregivers and family members. In addition to including education and training of family members which are sufficient to care for the patient at home, this strategy should also offer alternative support and coping for the disease, obtaining the most effective and personalized care. Coordinated hospital-home care would increase the patient's quality of life and provide caregiver support[5]. A study conducted in Norway with older patients pointed out that identifying patients who are clinically fit for discharge by informing the patient and their immediate family members about discharge, providing written information on post-discharge care transfer and arranging patient transport activities lead to successful discharge[6].

Several strategies can be adopted as a system for sharing information between the hospital and the health unit at hospital discharge, such as systematizing protocol-based user follow-up, management planning for discharge, case management, post-discharge telephone follow-up, contact phone number of the lead nurse responsible for the patient during hospitalization, a printed care plan, written educational material, leaflets with telephones and community service websites, nurse liaison, nurse educator, among others[7-8]. The counter-referral mechanism in the hospital setting may be able to enable care continuity after discharge to the patient in Primary Care and contribute to comprehensiveness in care. However, measures for its operationalization are required to adopt strategies to be executed and coordinated by professionals in order to overcome the simple act of forwarding patients. In other words, strategies and actions that really guarantee the user and their family/caregiver attendance of their needs at another point of the RAS.

Although the nurse is a professional who actively participates in care at various levels of the health system, a study conducted in João Pessoa (Paraíba state, Brazil) demonstrates the fragility of their contribution to the care continuity mechanism in Primary Care. The fragility is evidenced by the almost non-existence of articulation between hospital and health unit at the time of hospital discharge, a deficit in strategies which enable parents to care for babies after hospital discharge, and a lack of understanding by the user and family members about the need for care continuity[9].

In addition, nursing practices about the hospital discharge plan, a tool which favors care continuity, have not been developed in the Brazilian context, even though this is a recommended strategy by the national health system and the World Health Organization. This theme still needs to be better explored to move from a goal to something concrete, with the development of nurses' competencies with a view toward the discharge process being fundamental[10].

However, nurses have a relevant role in care continuity between different care levels in countries such as Canada, Portugal and Spain. A multicenter study is currently being developed in these three countries, and this article presents the Spanish context.

In Spain, the Catalan Health Service (*CatSalut*) Program for the Preparation of Hospital Discharge (PRE-DISCHARGE – *PREALTA*)[11] was developed in the Catalonia region in Barcelona in order to achieve the abovementioned objectives. This program was created from the need perceived by health professionals to establish care continuity after hospital discharge. In addition, the program aims to improve the care quality, improve and rationalize the use of resources and services, improve health outcomes, quality of life, and patient and family member satisfaction. PRE-DISCHARGE has been configured as an instrument to improve coordination between primary and specialized care as a space of consensus, cooperation and territorial management. In Spain, Case Management Nurses or Continuity Care Nurses are also called Hospital Nurse Liaisons, and

coordinate with health professionals so that the most appropriate care plan for each situation can be established together with the patient and the family[11].

Given the need to implement *RAS* in the Brazilian reality with the consequent continuity of patient care, and considering the successful experience of Hospital Nurse Liaisons in Spain, this study aimed to learn the profile and activities performed by these nurses in University Hospitals in Madrid and Barcelona.

METHOD

Study design

An exploratory study implementing a qualitative approach.

Scenario

Developed in Madrid at the San Carlos Clinical Hospital, Getafe Hospital, Severo Ochoa University Hospital, Doce de Octubre Hospital and the Puerta de Hierro Hospital in Majadahonda, and in Barcelona at the Bellvitge University Hospital, Vall d'Hebron Hospital and Germans Trias Hospital.

Study population

The participants were 19 Hospital Nurse Liaisons working in university hospitals in Madrid (8) and Barcelona (11), and were selected because they perform counter-referral in a systematic and consolidated manner, which enables care continuity between hospital care and Primary Care. The recruitment of these nurses was facilitated through the support of an informant researcher from Madrid and another from Barcelona, with both having knowledge about the study objective. A visit was made by the main researcher at these hospital institutions in January and February of 2017, and presented the research Project.

Data collection

An online questionnaire was used for data collection with open and closed questions, questions about the profile, patient evaluation, hospital resources and services for care continuity, discharge plan, hospital nurse and Primary Healthcare communication, follow-up after hospital discharge, rehospitalization, facilities and difficulties for the care continuity and skills and competence of the hospital nurse liaison.

The questionnaire was written in Portuguese to respond to the objectives of the multicentric research and was later adapted and validated in the languages where it was applied. In the case of Spain, it was translated into Spanish and sent to the informed researchers in Madrid and Barcelona. The initial translation had to be carried out by at least two different translators and native speakers of the target language, reducing the risk of linguistic and cultural biases of theoretical and practical comprehension[12-13]. After translating the instrument, the informed researchers validated the content, the relevance of the questions and their format[14]. The questionnaire was subsequently inserted on the Survey Monkey[R] platform, which is an electronic tool with private access which enables creating, applying, collecting and analyzing data through the Internet with privacy and data security, and was contracted by the main researcher. Participants received an e-mail with an invitation and a web link, which led them to the Survey Monkey electronic platform and immediate opening of the Consent Statement, which was a mandatory condition for opening the subsequent pages. Each question in the questionnaire needed to be answered so that the participant could move on to the next question. The estimated time for completion was 15 to 20 minutes. Anonymity was guaranteed, since the Survey Monkey Platform enables an activation of anonymous responses.

Data analysis and processing

The data were analyzed by implementing the Content Analysis technique in the Thematic modality. This consists of aggregating the key elements, resulting in defined categories which are in consonance with the research objectives and the literature on the subject[15]. The participants answered the questionnaire on the Survey Monkey Platform, then the data were transferred to a spreadsheet in Excel and shared among all the authors for the Thematic analysis.

Ethical aspects

This study is an integral part of the multicenter project, entitled "Strategies for network integration: nurse contributions" ("*Estratégias de integração em rede: contribuições do enfermeiro*") from the Graduate Program in Nursing of the Universidade Federal do Paraná. The project was approved by the Research Ethics Committee of the Universidade Federal do Paraná, Opinion no. 888.681/2014, and complied with the precepts of Resolution no. 466/12, of the National Health Council on research with human beings.

RESULTS

Reading, organizing and analyzing the produced data made it possible to construct two categories through a convergence of ideas: Work process and resources for care continuity in Primary Care; and Skills and competencies required for the Hospital Nurse Liaison. These categories were guided by the research, in which an attempt was made to establish proximity with the meanings revealed in the subjects' answers. The characteristics of the participants will be presented below in order to situate the reader.

Nineteen (19) Hospital Nurse Liaisons participated in the study. The participants' ages ranged from 26 to 64 years, in which 14 (73.67%) had ages between 41 and 60 years, and 18 of the participants (94.73%) were women. Regarding their experience as a nurse, 10 (52.63%) had between 21 to 30 years of work experience, followed by 6 (31.57%) with 31 to 40 years, and 3 (15.80%) had less than 20 years. Regarding their time in the role of Hospital Nurse Liaison, it ranged from 6 months to 26 years, and 10 (52.63%) presented less than 5 years. Only 11 participants (57.92%) had postgraduate degrees, and of these, 5 had Master's degrees, 6 had specialist degrees, and 4 were currently in their training

course related to chronic patients, natural and socio-health therapies. Regarding the work context, 10 nurses (52.63%) were working daily for 7 hours and 25 minutes, 6 (31.58%) worked for 8 hours, 2 nurses (10.52%) had 7.5-hour work shifts, and one (5.27%) worked for 7 hours. In this scenario of the studied institutions, 4 hospitals incorporate the services of one Hospital Nurse Liaison, 8 have two, and 7 have three Nurse Liaisons.

Work process and resources for care continuity in Primary Care

The Hospital Nurse Liaison is requested to carry out an evaluation and verify the need for care continuity after discharge through two mechanisms: consultation of the multiprofessional team, which may be through the computerized system (14; 73.68%), telephone contact (13; 68.42%), e-mail (09; 47.36%); in person (04; 21.05%); and/or interdisciplinary meeting (01; 5.26%); and/or active search in the Hospital's Computerized Program (*SELENE*) of inpatients aged 75 years or over; with associated comorbidities and clinical diagnosis. Some nurses reported that they actively and systematically searched the program every day.

The request for evaluation can be from the care nurse, doctor, social worker or the professionals responsible for the patient. They are generally from those who promptly intervene in care and who detect the need for care continuity upon hospital discharge. Responsibility is shared with unit nurses and their supervisors, but the decision for the need of post-discharge care continuity is the Hospital Nurse Liaison.

The Hospital Nurse Liaison makes an active search in the computerized SELENE program and finds the clinical and social data of the patients, as well as the hospitalization period. They then perform the Comprehensive Geriatric Assessment (CGA) to detect the patient and caregiver needs, analyze the situation before hospital admission and the care at hospital discharge.

There were five (26.31%) supervisory nurses, five (26.31%) physicians, five (26.31%) social workers, four (21.05%) nursing assistants, one (5.26%) discharge management nurse, and one (5.26%) Primary Care doctor in the hospitalization units of the study.

The majority (17; 89.47%) request the Hospital Nurse Liaison through a specific form, and only two (10.52%) do not use it. All Hospital Nurse Liaisons (19; 100%) interview patients, and the majority (13; 68.42%) perform clinical and social evaluations. The interview aims to identify the type of residence to which the patient will be referred after hospital discharge, the presence of architectural barriers and information about the caregiver.

The clinical evaluation of the patient is expanded to include physical, functional, cognitive, mental, social and emotional domains. Several protocols are used, including: The Gordon, Barthel, Pfeiffer, and Zarit standards, nutritional status, complex care (wounds) and caregiver information. The health network, family support network, capacity for self-care, social risk questionnaire (*TIRS*), new hospitalizations, therapeutic management and degree of dependence are verified in the social evaluation. All the Hospital Nursing Liaisons (19; 100%) reported communicating the evaluation and the importance of care continuity by Primary Healthcare to the family.

All Hospital Nurse Liaisons (19; 100%) were knowledgeable about the resources needed to carry out care continuity after hospital discharge, and how to make contact with the professionals and/or nurses in the patient's area of origin (Primary Care, Nursing Centers, Health, Hospital and/or Residence) by telephone or e-mail and the computer tools shared between the services.

Via the medical report and discharge nurse, the computer program (SELENE) history is checked and other professionals of the PRE-DISCHARGE Program are contacted, ensuring a visit to the patient in the Primary Care until the next 48 hours after hospital discharge performed by a health professional (nurse or physician) of Primary Care.

Hospital Nurse Liaisons make visits to the Health Centers to know how these services work. The Continuous Care Committee is formed by professionals who participate in meetings in Primary Care and develop protocols and working documents around care continuity at hospital discharge.

The information provided by the patient care team in the hospital is critical to establishing the patient discharge plan. The professionals request the Hospital Nurse Liaison, the evaluation and the case discussion, and the nurse prepares the PRE-DISCHARGE report (16; 84.21%) in the care unit before discharge.

In the health units or in the home, Primary Care nurses work directly with the Home Care Program and Support Team (*PADES*), mainly with patients in palliative care. Coordination between the hospital and Primary Care is done through an electronic platform by the Primary Care Nurse.

There are consultant nurses in some areas and a group of residents who work directly in Primary Care. The interaction with the PADES team and the hospitals has as objective to realize and to extend the care continuity and to provide hospital equipment in the hospitalization residence.

Skills and competencies required for hospital nurse liaisons

The Nurse Liaison develops a unique role within the Hospital Unit. To do so, some competencies and abilities are inherent to the function and mentioned by the participants as essential to acting in the profession, such as having experience in dealing with difficult situations and handling care with complex patients and their family, having evidence-based knowledge for care continuity, knowledge of the in-hospital devices, the sociodemographic characteristics of the area of influence, and the resources available for patient discharge. The ability to be an educator and to work as a team, have empathy, self-control, initiative, responsibility and motivation was also stressed. Participants understand that the Nurse Liaison is essential in the system between high complexity and Primary Care. This function enables managing the cases, which allows autonomy to the nursing professional, transmitting safety, quality, satisfaction, connection and care continuity.

DISCUSSION

Transitions from hospital care to the Primary Care of older adult patients with chronic diseases are complex and lead to increased mortality and use of the service. In response to these challenges, transitional care interventions are being widely implemented, including self-management education, discharge planning, structured follow-up, and coordination among different health professionals.

When care interventions were carried out in the transitions from the hospital to Primary Care, there was a lower mortality rate at 6, 12 and 18 months post-discharge, a lower demand rate for emergency services at 3 months, a lower readmission rate at 3, 6, 12 and 18 months, and a mean of readmission days at 3, 6, 12 and 18 months. There were no significant differences in quality of life. Managers should consider these results by developing policies and interventions to include transitions of older patients in the reorganization of health services[16].

Several changes are perceived in the daily lives of patients upon hospital discharge because they were not guided by the nurse during the hospitalization period, causing discontinuity in care. Sometimes the guidelines before discharge are incomplete and do not consider the patient's needs and their social context[4].

Several studies discuss "care management, with emphasis in the hospital sphere, with analyzes focused on organizing care and guidelines for self-care"[17], in a context of epidemiological and demographic transition around the world. The studies suggest the need for a change in the care model, which should be more patient-centered and complex and prolonged care which values the autonomy of users and families. The nurse must constantly seek strategies which overcome the challenges and difficulties of bureaucratized care management and potentialize self-care.

Care management "is a central and predominant practice in nursing work. The challenges to comprehensive practices are in the possibilities of interconnection between thinking and doing health, defined by politics, management, technical procedures and collective interaction in the act of producing care"[17].

Case management first appeared in the United States in the late 1960s and early 1970s, and was later extended to other countries, notably Great Britain, Canada, Australia, Israel, and the Netherlands. Such management is defined as a collaborative process by which services are offered to meet the health needs of a person and their family. People who are susceptible to case management are fragile, vulnerable or complex, have functional disabilities, a lack of social and family resources, are socially isolated, and therefore need support in basic activities, instrumental activities of daily living, and help in their therapeutic regime; in short, they require multiple resources of the health network and need multidisciplinary and continuous care[18].

A study carried out in nine hospitalization units of a university hospital in Southeastern Brazil about nursing care product evaluation showed that the items which were weighed negatively were related to interaction and multidisciplinary performance (59.9%), and to the monitoring and transference of the care (28.5%). These issues seem to advance slowly in face of the complexity of interventions and the need to link knowledge and team integration.

Thus, interdisciplinary teaching and practice have been researched and currently encouraged in areas in order to improve fragmented health systems by turning them into a viable and efficient model of service delivery. Another challenge, evidenced in this study and which corroborates other findings, relates to the information transfer between clinical teams through formal registration, thus reducing adverse incidents and improving the continuity of healthcare[19].

In Spain, the Hospital Nurse Liaisons work in a multidisciplinary team, but the care continuity decision is their responsibility, and the discharge communication is carried out by the computerized system and/or telephone by the Primary Care Nurse.

A study carried out in the North and Central regions of Portugal with the objective of analyzing nurses' perceptions about the care of hospitalized older adults in clinical and surgical units showed that some managerial measures are necessary to improve care: a) collaboration between the disciplines (interdisciplinarity, use of geriatric protocols, management of conflicts which may arise when caring for older adults); b) geriatric education, training for health professionals, equipment and resources adapted for older adults; c) focus on patient/family-centered care; d) evidence-based geriatric nursing protocols for best practices; e) institutional policies based on the care needs of hospitalized older adults; f) partnerships with other health and/or social care institutions to promote the continuity of effective, efficient and safe care[20].

Appropriate planning for hospital discharge is critical to care continuity and to minimize the negative repercussions for the patient and their family members. To this end, the Nurse Liaison should show experience in their daily work and be provided with knowledge that permeates the scientific knowledge brought by the participants, but must also be equipped with the knowledge about the transition from individualized, non-fragmented, person-centered care, with a view to the different needs and responses to interventions, seeking to ensure that the patient and family feel safe, prepared and supported at home[21-24].

Teamwork as an essential skill is reported by studies which point out that care continuity management involves numerous actions which require multiprofessional action, a better understanding of each other's roles, as well as an integrated health system that reduces the transition barriers from high complexity to Primary Care[22,25-26].

There is also a need to reinforce the skills of Hospital Nurse Liaisons regarding empathy, self-control, initiative, responsibility and motivation; characteristics which translate into the proactivity and autonomy of the nurse when assuming the problem resolution with strategies based on programmatic actions and health education, at any level of complexity[21-22]. In teamwork, "interaction among participants, communication, trust, mutual respect, shared

decision-making, collaboration, care coordination and recognizing the roles of professionals are all important"[25].

It is known that nurses who work in the hospital area perform multiple tasks with a high level of demand, and these tasks can interfere in the quality of care, depending on the way their work is organized and the adopted knowledge and leadership practices. In this direction, it can be inferred that management skills are essential and can be developed and aggregated to care through leadership practices[27].

Regarding education, in the sense of the Hospital Nurse Liaison's ability to educate, this should be based on the experience of changes in the patient's health status, needs for care, and difficulties encountered by the family in facing new situations. The purpose of education is to promote care in the patient's home and must be a constant practice in the daily life of this professional[24,28].

The participants' understanding of the essentiality of the Hospital Nurse Liaison in the context of hospital discharge converges with studies which point out the importance of the professional's role in care management, in planning the transition between the hospital and the home with greater efficiency in the procedures, and conclude that care transition results in improved quality of care and a reduction in preventable readmissions[21,23,29-30].

This study presented a limitation in the number of subjects and municipalities, since it was only carried out in three university hospitals in Barcelona and five in Madrid, and with an average of only two Hospital Nurse Liaisons from each hospital.

It is suggested that new research be carried out in other regions of Spain. We hope that this study contributes to strengthening the principles and guidelines of the Unified Health System, and that the nurse is the articulator between the levels of care as well as being the professional responsible for care continuity.

CONCLUSION

The activities carried out by nurses at University Hospitals in Madrid and Barcelona related to care continuity for Primary Care encompass the specificity of the work process, the availability of resources and the individual skills and competencies to perform the function of linking the care levels.

The Hospital Nurse Liaison is requested to perform clinical and social assessment and verify the need for care continuity after discharge through consultation with the multiprofessional team or via an active search in the Hospital Computerized Program. There is family involvement together with the multiprofessional team in this process to elaborate the patient discharge plan. The hospital nurse has knowledge about the resources needed after hospital discharge and contacts the professionals and/or nurses in the patient's area of origin. Coordination between the hospital and Primary Care is done through an electronic platform by the Primary Care nurse.

Among the skills and competencies to act as Hospital Nurse Liaison or in the continuity of care, it is necessary to have experience in dealing with difficult situations and care management of complex patients and their family. In addition, knowledge of intra- and extra-hospital devices, ability to perform teamwork, leadership, computer skills and effective communication with different levels of complexity.

RESUMO

Objetivo: Conhecer o perfil e as atividades realizadas pela Enfermeira Hospitalar de Enlace para a continuidade do cuidado na atenção primária à saúde na Espanha. **Método:** Pesquisa do tipo exploratória, de abordagem qualitativa, desenvolvida em cinco Hospitais Universitários em Madri e três em Barcelona, com Enfermeiras Hospitalares de Enlace que atuam nos Hospitais em Madri (oito) e Barcelona (11). Para a coleta de dados foi aplicado um questionário *on-line*, com perguntas abertas e fechadas. Os dados foram analisados pela técnica de análise de conteúdo, na modalidade temática. **Resultados:** Participaram 19 Enfermeiras Hospitalares de Enlace. A faixa etária variou de 26 a 64 anos, a maioria era mulheres (94,73%) com experiência entre 21 e 30 anos (52,63%), trabalhando nesta função entre 6 meses e 26 anos. Antes da alta hospitalar, a Enfermeira é solicitada a realizar a avaliação clínica do paciente e contato com o Enfermeiro da área de origem do paciente por telefone ou *e-mail*. É necessário ter capacidade como educador, trabalhar em equipe e motivação. **Conclusão:** Na Espanha, a Enfermeira realiza a continuidade de cuidado para a atenção primária à saúde, cujas atividades englobam disponibilidade de recursos e experiência no manejo do cuidado de pacientes complexos e sua família.

DESCRITORES

Cuidado Transicional; Alta do Paciente; Continuidade da Assistência ao Paciente; Enfermagem em Saúde Comunitária; Enfermagem Domiciliar; Integralidade em Saúde.

RESUMEN

Objetivo: Conocer el perfil y las actividades realizadas por la Enfermera Hospitalaria de Enlace para la continuidad del cuidado en la atención primaria de salud en España. **Método:** Investigación del tipo exploratoria, de abordaje cualitativo, desarrollada en cinco Hospitales Universitarios en Madrid y tres en Barcelona, con Enfermeras Hospitalarias de Enlace que actúan en los Hospitales en Madrid (ocho) y Barcelona (11). Para la recolección de datos se aplicó un cuestionario en línea, con preguntas abiertas y cerradas. Los datos fueron analizados por la técnica de análisis de contenido, en la modalidad temática. **Resultados:** Participaron 19 Enfermeras Hospitalarias de Enlace. El rango de edad varió de 26 a 64 años, la mayoría eran mujeres (94,73%) con experiencia entre 21 y 30 años (52,63%), trabajando en esa función entre 6 meses y 26 años. Antes del alta hospitalaria, se solicita que la Enfermera lleve a cabo la evaluación clínica del paciente y el contacto con el Enfermero del área de origen del paciente por teléfono o email. Es necesario tener capacidad como educador, trabajar en equipo y motivación. **Conclusión:** En España, la Enfermera realiza la continuidad de cuidado para la atención primaria de salud, cuyas actividades abarcan disponibilidad de recursos y experiencia en el manejo del cuidado de pacientes complejos y su familia.

DESCRIPTORES

Cuidados de Transición; Alta del Paciente; Continuidad de la Asistencia al Paciente; Enfermería en Salud Comunitaria; Cuidados de Enfermería en el Hogar; Integralidad en Salud.

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